IOWA DEPARTMENT OF HUMAN SERVICES

Child Care Complaint

Name of Provider Jenna Dale	**County** Warren	
Care Address 403 N K ST	**City** Indianola	**Zip Code** 50125
Mailing Address 403 N K ST	**Mailing City** Indianola	**Mailing Zip Code** 50125
Phone [redacted]	**Email**	

Date of Complaint:	04/04/2019	**Date of Visit:**	04/17/2019

Type of Visit

[X] Scheduled [ ] Unannounced [ ] N/A

Compliance Regulation

[X] Non-Compliance with Regulations Found [ ] Compliance with Regulations Found [ ] Scheduled

Recommendation for Registration:

[ ] No Changes to registration status recommended

[X] Revocation of Registration

[X] Cancellation of Child Care Assistance Provider Agreement

Category of Care:

[ ] Category A

[X] Category B

[ ] Category C (with no co-provider)

[ ] Category C (with co-provider)

[ ] Non-registered Child Care Home with CCA Provider Agreement

Complaint Details:

Did this complaint result in a serious injury? ☒ Yes ☐ No

Serious Injuries include:

- Disabling mental illness.
- Bodily injury which creates a substantial risk of death, causes serious permanent disfigurement, or causes protracted loss or impairment of the function of any bodily member or organ.
- Any injury to a child that requires surgical repair and necessitates the administration of general anesthesia.
- Includes but is not limited to skull fractures, rib fractures, metaphyseal fractures of the long bones of children under the age of 4 years.

Did this complaint result in a death to a child? ☒ Yes ☐ No

Summary of Complaint:

On 4/4/19, the Department of Human Services received a complaint regarding registered Category B Child Development Home Provider, Jenna Dale. A one year old daycare child was found unresponsive in Jenna's daycare residence. The child had been sleeping in a pack and play and wearing an amber teething necklace. Jenna called 911 and when Emergency Medical Services arrived, Jenna's husband, Michael Dale, was administering CPR. The child's parent indicated the child would also wear the teething necklace at home. The child arrived at the hospital at 1:10 p.m. and was pronounced dead at 1:20 p.m.

Rule Basis and Findings of Complaint(s):

Code of Iowa, Chapter 237A / 441 Iowa Administrative Code Chapter 110

RULE(S):
110.6 No more children are in care than the number authorized on the registration certificate.

110.7(1) The provider meets the following requirements:
a. Gives careful supervision at all times.
c. Gives consistent, dependable care.
Is capable of handling emergencies.
d. Is present at all times, except if emergencies occur or an absence is planned.
If an absence is planned, care is provided by a DHS-approved substitute.

110.7(2) Substitutes. The provider shall assume responsibility for providing adequate and appropriate supervision at all timeswhen children are in attendance. Any designated substitute shall have the same responsibility for providing adequate and appropriate supervision. Ultimate responsibility for supervision shall be with the provider.
a. All standards regardingsupervision and care of children apply to substitutes.
e. The provider maintains a written record of the number of hours substitute care is provided, including the date and the name of the substitute.

110.8 Conditions in the home shall be safe, sanitary, and free from hazards.

110.8(1)
c. Combustible materials are kept away from furnaces, stoves, gas dryers, or water heaters by a minimum of three feet.
o. Injury report forms are maintained for any injury requiring first aid or medical care. The forms are completed on the date of occurrence, shared with parents, and copies are in the child's file.
s. Serious injuries and deaths are reported within 24 hours.

110.8(3) Medications and hazardous material.
a. All medicines and poisonous, toxic, or otherwise unsafe materials are secured from access by a child.

110.9 Files
110.9(1) A provider file is maintained and contains:
b(2) Documentation from the Department confirming record checks have been completed and authorizing or limiting the person's involvement with child care.

110.14(1) Specific Requirements For Child Development Home Category "B"
a. Not more than 6 preschool children present at any one time including infants.
d. Not more than 2 children who are receiving care on a part-time basis at any one time. Part-time hours are limited to less than 180 hours per month.

FINDING(S):

In speaking with DHS worker, N. Gregg on 4/4/19, 9 daycare children under the age of 5 were present at the time a child was found unresponsive in Jenna Dale's home. The laundry/furnace room was being used for multiple daycare children to nap. No windows are in this room and there is access to multiple items that are hazardous to children, including laundry detergent. There were five pack and plays in the laundry/furnace room and a sixth pack and play was resting up against the furnace. The pack and play resting up against the furnace was the location where the unresponsive child had been napping. There are concerns that Jenna did not check on the unresponsive child for a period of two hours.The child was sleeping with a bib and teething necklace around their neck. A baby monitor, with audio capability only, was set up and sitting on the dryer in the furnace/laundry room. There were concerns that when the dryer was in use, little could be heard on the monitor.

On 4/8/19 at 1:00 p.m. myself and an additional DHS social worker attempted an unannounced visit to Jenna's daycare residence. The individual who answered the door reported Jenna was at a hair appointment and was not present. A business card was left. On 4/9/19 at 10:50 a.m., myself and an additional social worker made a second unannounced visit to Jenna's daycare residence. There was no answer to the door or phone at this time; a voicemail was left requesting contact be made to schedule a visit. At 11:20 a.m. Jenna returned my phone call. She was upset and reported a baby died in her care and she had been at the funeral service when DHS attempted to visit her. Jenna stated she did not know if she would be resuming childcare. She reported she had watched children in this particular family for the past 12 years. I explained a child care complaint had been received regarding the unresponsive child in her daycare and a visit would be needed to further discuss daycare rules and regulations. Jenna reported she was not in a position to have a visit until next week; a visit was scheduled for 4/17/19 as Jenna reported she would be home all day.

On 4/17/19 at 11:00 a.m. myself and two additional DHS social workers conducted a scheduled visit with Jenna at her daycare residence. At the time of our arrival, no daycare children were present as a safety plan was in place requiring Jenna not provide any childcare.

Jenna was made aware there were concerns regarding health and safety, over capacity, supervision, and hazardous environment(children sleeping in a furnace/laundry room) stemming from an incident on 4/3/19 in which a one year old child was found unresponsive in her care.

Jenna acknowledged she had 9 children in her care, which is over capacity, on the date of the incident. She reported that she found out at the last minute she would be getting an additional child in care that is not typically present. Jenna stated she quickly set up an additional pack and play for this child.

Jenna reported the children are typically down in the basement in the large main area so children can be heard. The child found unresponsive, was laid down for a nap around 10:30 a.m.; a baby monitor was reportedly set up so the child could be heard while Jenna was upstairs cooking lunch. Initially, Jenna reported she went downs stairs to restart the dryer, but today she reported the dryer was not on during the time of the incident. Jenna was asked why she uses the furnace room for naps rather than the large main room in the basement. Jenna responded that the children are inquisitive and they would get into things in the large room, which also serves as her adult son's bedroom. Jenna stated she thought the furnace room would be a better place for daycare children to sleep as it offered more containment. Jenna was made aware that there are multiple hazards in the furnace room that the children could have access to, particularly without direct adult supervision, including laundry detergent, multiple spray bottles, electrical box/cords, and direct access to the furnace, water heater, washer/dryer. Jenna recalled during her last daycare compliance visit nine or ten months ago, she believed she had children sleeping in the furnace room at that time without issue. I cited the previous compliance worker had been in the home in March 2018. Jenna was reminded that the previous compliance worker also cited noncompliance in 2017 for having clothing/flammable items too close to the furnace. Jenna was asked why she would put a pack and play with a child in it next to the furnace after being previously cited for this issue. Jenna reported the child in question was "socially different" and needed to be placed away from the other children. Jenna stated some children take themselves downstairs for nap time and climb into their pack and plays. There are other children that are helped downstairs to take a nap. The child found unresponsive was placed down for a nap at 10:30 a.m. and was the only child in the furnace room at that time. At 11:30 Jenna reported taking another child down for their nap. She stated she typically checks on the children 2-3 times during their nap time. However, on 4/3/19, she reported being in a hurry to tend to other children upstairs, clean up from lunch, and pick up a household member from school so she admitted she did not check on the child found unresponsive when she took the other child down for a nap at 11:30 a.m. Jenna reported she did not check on the child found unresponsive until she returned from her school pick up around 12:15 p.m. or 12:20 p.m. The child had been put down for a nap nearly two hours prior and had not been checked on during that time. Jenna reported she went down stairs to restart the dryer and found the child unresponsive and cold to the touch.

When Jenna found the child unresponsive, she ran upstairs with the child and yelled for Michael Dale to help her. Michael started CPR on the child and Jenna called 911 and then the child's parent. Jenna reported on 4/3/19, the child who was found unresponsive went to sleep with a teething necklace and a bib that snaps in the back. The child was teething and frequently drooled so wore these items daily. Jenna reported the child typically arrived wearing the teething necklace and she would often forget it was even on. Jenna stated she broke the teething necklace off before

Michael started CPR and noted small indentations in the child's neck similar to marks a sock would leave on the leg/ankle area when worn. Jenna reported the child began wearing the teething necklace around 3-4 months of age and she believes the necklace was also worn at home.

Jenna reported that her husband, Michael Dale, is a substitute/assistant and helps with care on a daily basis. Jenna stated she regularly picks up children from school during the day. Michael is typically the person who is with the daycare children in her absence from approximately 11:00 a.m until 12:15 p.m.. I advised that Michael is not currently listed on her registration as an approved substitute/assistant. Jenna claimed this was a surprise to her. I inquired if Jenna had any paperwork from Registration indicating he is approved but she was unable to locate this at the time of the visit. I also inquired about Michael's required trainings, necessary for functioning in a substitute role, including infant/child CPR/First-Aid, Mandatory Child Abuse Reporting Training, and Health and Safety Essentials. Jenna was unable to locate these trainings during our visit but stated he is current on his trainings. I requested Jenna locate the current certificates and send them to me for verification. Jenna never notified me of any current trainings regarding Michael. In checking with Child Care Resource & Referral, there is no record in Jenna's provider portal for any of Michael's trainings. In further review of DHS's KinderTrack system, Jenna was renewing her child care registration in June 2018. At that time, Jenna was adding Jalyn Dale as a substitute/assistant and renewing Michael's substitute/assistant status. On 5/30/18, Registration has documentation that staff spoke to Jenna about needing Michael's trainings by 6/11/18 to approve him as a substitute/assistant on her renewed registration. Michael was changed to a household member in June 2018 because the required training was not submitted to the registration unit timely. Michael was not an approved substitute/assistant on 4/3/19 when this incident occurred and has not been approved in this role since June 2018; Jenna has been aware of this. Jaylyn Dale's substitute/assistant status was approved in June 2018 and she is currently an approved substitute/assistant. In speaking with a collateral contact, Jenna reported Jaylyn had been sleeping in the upstairs portion of the home during the time of the incident on 4/3/19, however, Jenna stated to me that she was awake and present.

There was a concern that the agreement that Jenna would not provide any childcare was being violated. Jenna denied any violation of the agreement and reported she has not cared for any children. She stated that a caregiver of some of her daycare children stopped by the house to visit. She also reported her substitute/assistant, Jaylyn, has been watching these children at the caregiver's residence. She denies any billing for care has occurred and denies that any of the care occurred at her residence. Jenna was asked if she had transported children since the agreement not to provide care was made. She stated on 4/10/19 she did pick up two children from the caretaker's home and transported them to school. She stated Jaylyn was not able to do this because she is not on the schools list to drop off/pick up. I inquired if Jenna was aware the transporting children qualifies as providing care and that this is something she is not currently approved to do. Jenna reported she was not aware that driving the children was considered providing care. I reminded Jenna that a previous corrective action letter cited concerns regarding an unapproved individual providing transportation to daycare children. There were previous conversations regarding transportation being a form of care provided to children. Jenna agreed she would not do any transportation or care moving forward and agreed to sign a child care safety plan specifying no care will be provided until written permission is granted, no care will occur at her registered address, she will not transport, and no assistants or substitutes will provide child care in her absence, until written permission is granted. The child care safety plan was signed by Jenna on 4/17/19.

There is evidence to support NONCOMPLIANCE with regulations regarding over capacity, health and safety, supervision, hazardous environment, combustible materials near furnace, and unapproved individual caring for children and serving in a substitute role. Noncompliance with unapproved individuals caring for children and having combustible materials are issues of repeated noncompliance.

Resolution and Action Required:

A full compliance visit was also conducted at this time, multiple areas of noncompliance are sited (See July 2019 Corrective Action Letter).

The concerns are of a serious nature and Jenna has not demonstrated insight or appropriate decision making to suggest that these concerns can be safely resolved.

Revocation and prohibition from child care and cancellation of Child Care Assistance Agreement due to the serious and repeated nature of the health and safety concerns.

Consultant's Signature:	Melissa Crawford	**Date of Visit:**	07/01/2019
Supervisor Signature:	Jone Staley	**Date of Visit:**	07/10/2019